OMB CONTROL NO. 0412-0520, EXPIRES 06/30/97

USAID CONTRACTOR EMPLOYEE PHYSICAL EXAMINATION FORM

PAPERWORK REDUCTION ACT INFORMATION: The information requested by this form is necessary to determine the physical ability of the individual to perform duties overseas. The Physician Statement at the end of the form may be used by USAID contractors and USAID contracting officers to make such a determination with regard to work overseas on an USAID contract. Medical information provided may be used by embassy health units to approve or disapprove the use of the health unit by USAID contractors and their dependents. Failure to provide the information requested by this form may result in an individual being denied overseas employment under an USAID contract and/or access to the U.S. embassy health room in a cooperating country.

TO BE COMPLETED BY EXAMINEE *(Please print all sections in INK or use TYPEWRITER)*

1. NAME OF EXAMINEE *(Last, First, Middle)*			2. CONTRACT NUMBER	3. DATE
4. DATE OF BIRTH	5. PLACE OF BIRTH	6. SEX	6a. CITIZENSHIP	6b. SSN *(Employee)*
7. MAILING ADDRESS IN THE U.S. Phone Number: ( )			8. NAME AND ADDRESS OF CONTRACTOR Contact person: Telephone: ( )	
9. NAME OF YOUR HEALTH PLAN			10. POST OF ASSIGNMENT Arrival Date: _____ Length of Tour _____	
11. IF DEPENDENT, FULL NAME OF SPONSOR:				

12. FAMILY HISTORY *(If relative has a chronic disease, Specify)*

Relation	Age	State of Health	If dead, cause of death	Age at Death
Father				
Mother				
Brother				
Sister				

Dependents Accompanying Employee	Age	State of Health
Spouse		
Child		
Child		
Child		
Child		

13. Has any blood relative *(parent, brother, sister, children)* had

YES	NO	*(Check each item)*	Relationship
		Allergies	
		Diabetes	
		Glaucoma	
		Heart Disease	
		High Blood Pressure	
		Cancer *(type)*	
		Emotional Disease	

14.
a. Examinee's statement *(or evaluation)* of present health:

b. Medication currently used *(Please list)*

ANSWER ALL QUESTIONS Do not use "PA" *(Previously Answered)*

15. DATE OF LAST EXAMINATION

Purpose of examination:

Result of examination:

16. Any special examination or treatment indicated at present time?

☐ Yes *(Specify)* ☐ No

17. Do you have any condition which would limit your assignment because of climate, altitude, isolation, or other factors?

☐ Yes *(Specify)* ☐ No

PRIVACY ACT STATEMENT: This information is requested for the purpose of assisting the physician to determine your medical status. Failure to provide full information concerning your health could result in the hampering of the medical review process. The information on this form is solely used for medical and administrative purposes. No one other than the reviewing physician and staff will have access to the medical form and information without the examinee's written authorization.

CHECK EACH ITEM "YES" OR "NO", EACH ITEM CHECKED "YES" MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT		
YES	NO	
		18. Have you had any significant illness or injury not noted elsewhere? *(specify condition and dates)*
		19. Have you ever been a patient in a mental hospital or sanitorium, or been treated by a psychiatrist or psychologist? *(Give date, name of doctor and/or hospital, and type of illness)*
		20. Have you been denied life insurance? *(Give details)*

21. DO YOU NOW HAVE OR HAVE YOU EVER HAD THE SYMPTOMS LISTED BELOW? *(Indicate "Yes" or "No" To Each item)*

YES	NO	*(Check each item)*	YES	NO	*(Check each item)*
		Frequent or severe headaches			Kidney trouble, stone or blood urine
		Epilepsy, fits or fainting spells			Sugar or albumin in urine
		Eye trouble or visual defect in either eye			Diabetes
		Skin disease			Rheumatic fever
		Ear, nose or throat trouble			Arthritis, rheumatism or joint pains
		Severe tooth or gum trouble			Painful or "trick" shoulder or knee
		Asthma			Bone, joint or other deformity
		Hayfever or other allergies			Recurrent back pain; wear a back support or brace
		Shortness of breath			Recent gain or loss of weight
		Chronic cough			Malaria, amoebic dysentery or other tropical disease
		Coughing up blood			Stutter or stammer habitually
		Tuberculosis, or close association with anyone who had or has tuberculosis			Frequent trouble sleeping
					Nervous trouble of any sort
		Pain or pressure in chest			Depression or excessive worry
		Palpitation or pounding of heart			Attempted suicide
		Swelling of feet or ankles			Any drug or narcotic habit *(specify)*
		High blood pressure			
		Frequent indigestion			Excessive bleeding after injury or tooth extraction
		Stomach, liver or intestinal trouble			Any reaction to serum immunization, drug or medicine
		Gall bladder trouble or gall stones			Tumor, growth, cyst, or cancer
		Jaundice or hepatitis			Do you use alcohol?
		Rupture or hernia			Are you a cigarette smoker?
		Piles or other rectal disease			Do you use any medication regularly? *(specify)*
		Blood in or on stool, or black (Tarry) Stool			
		Frequent or painful urination			

FEMALES ONLY

Specify any GYN surgery or disease:

Date of last Menses:

I CERTIFY THAT I HAVE READ THE ABOVE INSTRUCTIONS AND ANSWERED ALL QUESTIONS TRULY AND COMPLETELY TO THE BEST OF MY KNOWLEDGE.

22. TYPED OR PRINTED NAME OF EXAMINEE	DATE	SIGNATURE OF EXAMINEE

NOTE For the Examining Physician: Please review the Medical History and make appropriate comments on all positive historical data. You are required to inform the examinee of any abnormality which you have noted and/or which may require medical attention.

23. SIGNIFICANT AND/OR INTERVAL HISTORY: ***(Note: the examining physician MUST COMMENT on all items checked "Yes" in items 16-21).***

REPORT OF MEDICAL EXAMINATION

(To Be Completed And Signed By the Examining Physician)

GUIDELINES FOR EXAMINING PHYSICIAN: The individual you are examining will be serving at one of a variety of overseas posts. Many of these posts are remote, unhealthful, and have limited or no medical support such as doctors, nurses, laboratory facilities, and hospitals. Many illnesses and injuries that can be handled routinely in developed countries such as the U.S., become major or life threatening problems in many underdeveloped overseas locations.

The effect of adverse environmental conditions, such as altitude, air pollution, poor sanitation, and exposure to tropical diseases, on any existing medical problem should be considered.

Please evaluate thoroughly all items listed on the examination form. It is most import that you:

- Comment on all items checked "Yes" on the medical history, items 15-21.
- Record all physical findings after completing the examination as requested.
- Order and record (or attach copies of) all laboratory and x-ray data requested. We do want all of the tests completed as requested for the age of the examinee. Guidelines for age are noted on this form.
- Comment on all indicated follow-up examinations and conditions that may require frequent observation or prolonged treatment.
- Sign and date that portion of the examination form completed by you.

24. RACE *(Check one)*
☐ White ☐ Black ☐ Other _____

25.
HEIGHT _____ in. or _____ cm.
WEIGHT _____ lbs. or _____ kg.

26. HEARING

SPOKEN VOICE: right ☐ normal ☐ abnormal
left ☐ normal ☐ abnormal

AUDIOGRAM: *(performed if indicated by gross evaluation)*

Frequency in Hertz and levels in decibels.

	500	1000	2000	4000
right				
left				

27. DISTANT VISION
right 20/ corrected 20/
left 20/ corrected 20/

28. INTRAOCULAR TENSION (Over Age 40)
right _____ mmHg left _____ mmHg

29. PULSE (Sitting)

30. BLOOD PRESSURE (Sitting)

CLINICAL EVALUATION: *(Describe every abnormality in detail. Enter pertinent item number before each comment.)*

NORMAL	Check Each Item As Indicated. Enter "NE" If Not Evaluated.	ABNORMAL	DESCRIBE ABNORMAL FINDINGS
	31. Head, Face, Neck and Scalp		
	32. Nose and Sinuses		
	33. Mouth and Throat		
	34. Ears – including otoscopi		
	35. Eyes – including ocular mobility, pupillary reaction and ophthalmoscopic (visual acuity under item 27)		
	36. Lungs and Chest *(includes breast)*		
	37. Heart *(thrusts, size, rhythm, sounds)*		
	38. Vascular system *(varicosities, etc.)*		
	39. Abdomen and Viscera *(includes hernia)*		
	40. Anus and Rectum *(hemorrhoids, Fistulae, Prostate)*		
	41. Endocrine System		
	42. G-U System		
	43. Extremities *(strength, range of motion)*		
	44. Spine, Other Musculoskeletal		
	45. Identifying body marks, scars, tattoos		
	46. Skin, lymphatics		
	47. Neurologic		
	48. Psychiatric *(specify any personality deviation)*		
	49. Pelvic (over age 21) (Papanicolaou done ☐)		Papanicolaou Result Class _____
	50. Sigmoidoscopy *(over age 50 or if indicated)*		

"ALL TESTS ARE REQUIRED UNLESS OTHERWISE SPECIFIED"

NAME OF EXAMINEE: *(LAST),* *(FIRST)*

51. HEMATOLOGY *(all ages)*		52. STOOL EXAM FOR OCCULT BLOOD] *(40 yrs. and over or when indicated)*	53. ECG *(40 Yrs. and over or when indicated)*. Submit all tracings.
Hematocrit	%		Result:
Hemoglobin	gms		
WBC	/cmm	a. Pos Neg	
Differential:		b. Pos Neg	
Granulocytes	%	c. Pos Neg	54. CHEST X-Ray *(Required for all examinations for persons age 18 and over or when otherwise indicated.)*
Lymphocytes	%		Date: Results:
Eosinophils	%		
Other	%	X3 on successive days	

55. SCREENING CHEMISTRY PROFILE TO INCLUDE: *(FASTING)* 18 yrs. and over	56. URINALYSIS *(all ages)*	57. TUBERCULIN TEST:PPD *(all ages)*	58. G6PD *(if going to Malarial areas)*
Blood Glucose	Specific Gravity	Date _____	Normal _____
Cholesterol	Albumin	Results: _____ mm of induration	
Creatinine	Sugar	Previously positive Yes ____ No ____	
Uric Acid	WBC		Deficient _____
SGPT	RBC	Previous BCG Yes ____ No ____	
SGOT	Casts	59. MAMMOGRAPHY *(suggested if over age 40 and if clinically indicated)*	60. SICKLE HEMOGLOBIN *(when indicated)*
Alk Phos	Other	Results and Date:	Present _____
Billrubin			Not Present _____

61. SEROLOGY *(specify test and results) (12 yrs. and over)*

STS _____ HIV *(optional)* _____

62. ASSESSMENT OF SIGNIFICANT FINDINGS	RECOMMENDATION FOR TREATMENT/FURTHER STUDY

63. TYPED NAME OF EXAMINING PHYSICIAN	SIGNATURE	DATE
ADDRESS: *CITY*	DATE	DATE
TELEPHONE		

PHYSICIAN STATEMENT
(To Be Completed and Signed By The Examining Physician)

Guidelines for Examining Physician: Please complete the following medical opinion based on the results of the REPORT OF MEDICAL EXAMINATION.

Guidelines for Examinee: A copy of this medical opinion shall be submitted by USAID contractor employees and their dependents to the appropriate USAID contractor. Personal Services Contractors and their dependents shall submit a copy of this medical opinion to the appropriate USAID contracting officer.

IN MY OPINION, THE EMPLOYEE _____ IS PHYSICALLY QUALIFIED TO ENGAGE IN THE TYPE OF ACTIVITY FOR WHICH HE/SHE IS EMPLOYED, AND EMPLOYEE AND/OR DEPENDENT _____ IS PHYSICALLY ABLE TO RESIDE IN _____ *(THE COUNTRY OF ASSIGNMENT).*

EXAMINING PHYSICIAN *(Type or print name)*	SIGNATURE	
ADDRESS *CITY* *STATE* *ZIP*		TELEPHONE